Black Therapist & Company, LLC

PATIENT INFORMATION

(COMPLETE SEPARATE FORM PER FAMILY MEMBER WHO WILL BE IN TREATMENT)

NAME: _____ DOB/AGE: _____

ADDRESS/PHONE: _____PRONOUNS_____

MARITAL STATUS: _____ RACE/ETHNICITY: _____

REFERRED BY: _____ MD _____ FAMILY _____ SELF _____OTHER

PRESENTING PROBLEMS: Specific symptoms/complaints that justify need for treatment
Include duration of symptoms. Estimate if unknown.

FAMILY HISTORY OF MENTAL ILLNESS:

PSYCHIATRIC HISTORY: (include prior treatment for psychiatric and substance abuse problems, including hospitalizations, suicide attempts/ideation, etc.)

NAME AND PHONE # FOR PSYCHIATRIST (IF ANY) _____

CURRENT MEDICATIONS AND DOSAGE (if any):

MEDICAL HISTORY:

NAME AND PHONE# OF PCP (IF ANY) _____

CURRENT SYMPTOMS (WITHIN THE PAST 30 DAYS) CHECK ALL THAT APPLY:

☑ DEPRESSED MOOD, ☑ SAD AFFECT, ☐ TEARFUL, ☐ DYSPHORIC, ☐ LOW SELF-ESTEEM, ☐ INAPPROPRIATE GUILT, ☐ FEELINGS OF WORTHLESSNESS, ☐ DIMINISHED INTEREST IN PLEASURABLE ACTIVITIES, ☐ WT. LOSS, ☐ WT. GAIN, ☐ INSOMNIA, ☐ HYPERSOMNIA, ☐ PSYCHOMOTOR RETARDATION,
☐ HOPELESSNESS/HELPLESSNESS, ☐ SOCIAL WITHDRAWAL/ISOLATION, ☐ RESTRICTED AFFECT, ☐ BLUNTED AFFECT, ☐ FLAT AFFECT, ☐ LABILE AFFECT
☐ PSYCHOMOTOR AGITATION, ☐ FATIGUE/LOSS OF ENERGY, ☐ DIFFICULTY CONCENTRATING, ☐ INDECISIVE, ☐ THOUGHTS OF DEATH, ☐ SUICIDAL THOUGHTS
☐ ANGRY, ☐ EUPHORIC, ☐ GRANDIOSITY, ☐ PRESSURE OF SPEECH, ☐ FLIGHT OF IDEAS, ☐ EASILY DISTRACTED ☐ HIGH RISK BEHAVIORS, ☐ ANXIOUS, ☐ IRRITABLE, ☐ FEARFUL, ☐ EXCESSIVE WORRY, ☐ HYPERVIGILANT, ☐ RESTLESS/FIDGETY, ☐ TREMBLING/SHAKY, ☐ MUSCLE TENSION, ☐ PANIC ATTACKS, ☐ AUDITORY HALLUCINATIONS, ☐ VISUAL HALLUCINATIONS, ☐ PARANOID DELUSIONS, ☐ DELUSIONS OF GRANDEUR, ☐ SOMATIC DELUSIONS, ☐ INAPPROPRIATE AFFECT, ☐ INCONGRUENT AFFECT, ☐ DISORGANIZED SPEECH, ☐ DISORGANIZED BEHAVIOR, ☐ PHOBIAS, ☐ OBSESSIONS, ☐ COMPULSIONS, ☐ LOOSE ASSOCIATIONS, ☐ BIZARRE BEHAVIOR, ☐ AGGRESSIVE BEHAVIOR: VERBAL / PHYSICAL, ☐ HOMICIDAL IDEATION, ☐ SUBSTANCE ABUSE
☐ OTHERS:_____

PROVIDE FURTHER DETAIL ON SYMPTOMS:

_____
_____
_____
_____
_____
_____
_____
_____

WHAT GOALS WOULD YOU LIKE TO ACHIEVE IN THERAPY?

☐ IMPROVE MOOD & AFFECT, ☐ STABILIZE MOOD, ☐ APPROPRIATE RANGE OF AFFECT, ☐ IMPROVE SELF-ESTEEM, ☐ REDUCE FEELINGS OF GUILT,
☐ INCREASE ENERGY LEVEL, ☐ INCREASE INTEREST IN PLEASURABLE ACTIVITIES, ☐ IMPROVE SLEEP PATTERNS, ☐ IMPROVE EATING PATTERNS,
☐ DECREASE THOUGHTS OF DEATH, ☐ DECREASE SUICIDAL IDEATION, ☐ IMPROVE CONCENTRATION,
☐ DEVELOP STRATEGIES TO REDUCE EXCESSIVE WORRYING/FEARS, ☐ IMPROVE ANGER MANAGEMENT SKILLS,
☐ DEVELOP RELAXATION STRATEGIES, ☐ IMPROVE COPING WITH PHYSICAL PROBLEMS/LIMITATIONS, ☐ IMPROVE COPING WITH LOSSES,
☐ IMPROVE ADJUSTMENT TO CHANGE IN LIVING CIRCUMSTANCES/REDUCED INDEPENDENCE, ☐ IMPROVE FRUSTRATION TOLERANCE,
☐ INCREASE REALITY ORIENTATION, ☐ IMPROVE COPING WITH PSYCHOTIC SX, ☐ REDUCE HOMICIDAL IDEATION,
☐ FACILITATE DECISION-MAKING/PROBLEM-SOLVING, ☐ ENHANCE ABILITY TO EXPRESS NEEDS APPROPRIATELY, ☐ REDUCE SUBSTANCE ABUSE
☐ REDUCE HIGH RISK BEHAVIORS (_____), REDUCE SOMATIC COMPLAINTS(_____)
☐ Others:_____
_____
_____
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